South Carolina Department of Social Services

NOTICE OF EXPIRATION

Your FS will expire: _____

To receive Food Stamps and/or FI without interruption, you must complete and return the form below with all proof of information to your local DSS Office as soon as possible, but no later than: _____

IMPORTANT – PLEASE READ THIS

- ANSWER ALL QUESTIONS ON THIS FORM. IF THE SPACE ON THE FORM IS NOT BIG ENOUGH FOR YOUR ANSWER, YOU MAY ATTACH AN ADDITIONAL SHEET OF PAPER.
- FAILURE TO ANSWER THE QUESTIONS CORRECTLY OR RETURN THE FORM BY THE DUE DATE WILL DELAY, REDUCE OR STOP YOUR FI CHECK AND/OR FOOD STAMPS.
- YOUR CASEWORKER MAY CONTACT YOU FOR ADDITIONAL PROOF OF ALL INFORMATION YOU PROVIDE ON THIS FORM.

INTERIM CONTACT FORM
FOOD STAMP PROGRAM

INSTRUCTIONS:

Please answer all questions completely.

If you need help with this form, call: _____

DATE RECEIVED-OFFICE USE ONLY	

	CASE NAME

CASE NUMBER		CASE LOAD ID

FOOD STAMP CERT. THRU DATE

CLIENT ID

We are conducting a yearly review of your eligibility for food stamps. Please answer all questions on the form completely. We will notify you if your benefit level changes.

1. Is the address listed on this form correct? ❑ Yes ❑ No
   If no, please list your new address and shelter expenses.

   Address: _____

   Rent/Mortgage: _____ Homeowner's Insurance: _____ Property Taxes: _____

   Do you pay for a heating or cooling cost? ❑ Yes ❑ No

   If no, list the utilities you pay for: _____

2. Has anyone moved in or out of your home in the past 12 months? ❑ Yes ❑ No

   Who moved in? Name: _____ Relationship to You: _____

   Date of Birth: _____ SSN: _____

   Does this person purchase and prepare their meals with you? ❑ Yes ❑ No

   Who moved out?: _____

3. List any money you receive each month.

   Source of Income: _____ Amount: _____ Who receives it?: _____

   Source of Income: _____ Amount: _____ Who receives it?: _____

   Source of Income: _____ Amount: _____ Who receives it?: _____

   Source of Income: _____ Amount: _____ Who receives it?: _____

4. You may make changes in your medical deductions once a year on this form. If you want a deduction for:
   - Out-of-pocket prescription costs – Send in proof of prescription costs for the past 12 months. You may attach an itemized listing of your prescriptions costs from your pharmacy.
   - Medical expenses you have incurred in the past 12 months which you paid or still owe – Send in proof of these expenses. This includes doctor visits, hospital visits, etc.
   - A health insurance premium that you pay other than Medicare – Send in proof of the amount of this premium.

   Please note: If proof of medical expenses is not provided, a deduction will not be given.

5. Do you know of anything in your household situation that is expected to change in the next 12 months? ❑ Yes ❑ No

   If yes, please list: _____

By signing below, I attest that the above information is true and correct.

Signature: _____

Date: _____ Telephone: _____

DSS Form 3808 (NOV 06) Edition of JAN 02 is obsolete. Replaces DSS Form 3808A.